Revista Romaneasca pentru Educatie Multidimensionala

Romanian Journal for Multidimensional Education

ISSN: 2066 – 7329 (print), ISSN: 2067 – 9270 (electronic)
Covered in: Index Copernicus, Ideas RePeC, EconPapers, Socionet, Ulrich Pro Quest, Cabell, SSRN, Appreciative Inquiry Commons, Journalseek, Scipio, EBSCO, CEEOL, ERIH PLUS

FAMILIES WITH A DISABLED CHILD, BETWEEN STRESS AND ACCEPTANCE. A THEORETICAL APPROACH

Camelia SOPONARU, Magdalena IORGA

Revista Romaneasca pentru Educatie Multidimensionala, 2015, Volume 7, Issue 1, June, pp. 57-73

The online version of this article can be found at:

http://revistaromaneasca.ro

Published by:

Lumen Publishing House

On behalf of:

Lumen Research Center in Social and Humanistic Sciences

Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach

Camelia SOPONARU[1]
Magdalena IORGA[2]

Abstract

Family is a hierarchically organized system, which mobilizes its capacity of linear and circular adjustment, of homeostasis, of modification, increase and change with each new challenge that it encounters. This paper focuses on the issue of stress in families with a disabled child, starting from the premise that the normal development and integration of the disabled child in society depend significantly on ensuring – within the family – a supportive, reassuring, adaptive climate. The family can create this climate by ensuring a positive relationship between the two spouses and by approaching correctly the child's disability. Mention must also be made of the positive influence of parenting training on parental stress and on enhancing the parental sense of competence.

Keywords:
disabled child; family; parenting; stress; reactions to trauma;

[1] PhD Associated professor, "Al. I. Cuza" University of Iasi, Romania, puzdriac@yahoo.com.
[2] PhD lecturer, University of Medicine and Pharmacy "Gr. T. Popa" of Iasi, Romania, magdaiorga@yahoo.com, 0040722800936, (corresponding author).

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

1. A brief incursion in the universe of the concept of family

The family represents one of the oldest and most significant social links that has ensured the continuity and full expression of the human being. As institution, family provides stability to a society, reason for which it is protected by written laws and by customs. Family defines society during a certain civilization stage, but it also marks profoundly the destiny of all individuals. For each person, settling down is an important step in life.

From a *systemic* perspective, family has the features of a system, because it is characterized by its adjustment capacity. This adjustment can be linear and circular. The family has the homeostasis capacity of keeping things in balance, but it also encompasses the capacity to alter, to grow, to change. Family is a hierarchically organized system, which comprises several subsystems, among which the most important are the conjugal subsystem, the subsystem of the parents and the subsystem of the siblings. The family system is open both outwards (to integrate information from the environment) and inwards (for self-protection, by living through its own means, by having its own values, rules and norms etc).

2. Impact of the diagnostic upon the family

Much thought must be given to the moment when the family finds out that they have a disabled child, because it can have significant consequences depending on the psychological structure of the parents, on their sociocultural level and on the level of values and beliefs that they share. The socio-familial tolerance towards the disabled child varies considerably: it is higher in the rural world, in less developed countries, but lower in highly industrialized and urbanized countries and in the families with few children.

Some parents cannot accept that their own child has a disability: they do not admit the reality, but they reject and they fight it, they deceive themselves, they lie to themselves and they look for explanations. This sudden and painful reality turns the family life upside down, and its members need specialized care and assistance. The family oscillates between the tendency of rejecting the child and that of over-monitoring him/her.

Generally, parents of disabled children *go through six evolution stages after learning the news: scepticism, guilt, rejection, shame, denial and helplessness.*

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

There are situations when an actual abandonment occurs, which (Păunescu, 1983: 136) can be as follows:

- total – when the parents cannot cope with the failure of having a child who makes them feel inferior in the society. In this case, the child's suffering will be total and his development will be delayed.
- partial – when one of the parents is no longer interested in the child's life, and the other (most of the times the mother) becomes overstressed, impatient, emotionally aggressive to the child, thus traumatizing him/her. This parent tries to blame the destiny and he/she can have two attitudes: lack of interest/abandonment or a total emotional fixation for the disabled child, thus giving up on his/her own life.

Referring to the parents' reaction, we will find several typologies of parents: parents who deny the obvious and wait for a miracle; nervous parents who look for a miracle; parents always unhappy with the educational methods; pessimistic parents, who sometimes feel guilty, who believe that everything is useless and who stop trying anything; realistic parents who try to understand objectively the situation and to cooperate (Lăzărescu, 1994).

There is a dynamic marked mostly by a series of questions that the parents ask themselves concerning their child and their situation. The question "Why did this have to happen to me?" appears when the family learns about the existence of the disabled child, meaning when they get the diagnostic. A second phase after learning an unequivocal diagnostic and after the first inherent reactions is the one when the parents are preoccupied with answering to "What can I do for my child?" In this phase, informing the parents about what they can do is crucial.

The psychological impact experienced by the families with a disabled child is represented by shock, denial and a great deal of pain, similar to the reactions following an irreparable loss. The family either adapts or mobilizes efficiently or it gets stuck in reactions with various degrees of rigidity and inefficiency. Some of the parents tend to resist to or reject the specialists' diagnosis. The life of the family with a disabled child suffers a series of alterations; the stress and exhaustion of the parents are associated with the slow progress of the child. (Sztankovszky & Iorga, 2015)

It is particularly important to facilitate a normal integration of the child and later of the adult in the big social community, through school

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

and then through profession, but the evolution of his/her personality is equally important. (Iorga et all, 2014) This person is part of a family that suffers the consequences of his/her disability; however, by not paying sufficient attention the family can become as non-involved or withdrawn from social life as the disabled person.

3. The child's disability – source of stigmatization and stress for the family

Irrespective of the era or of the theories, when a disabled person becomes part of a family, an alteration occurs that affects both the "inner balance" and the "outer balance" – which concerns the relations between the family and the society.

The family perceives the handicap of the child as its weak point in the relationship with society, and society uses it as discriminating criterion in the perception of the family. Society will no longer have a global, overall perception of the family, but a unidirectional view: the family defines its position in the society mostly through the child's handicap. Erving Goffman states that society sets procedures that serve at categorising the persons and attributes that they appraise as normal and habitual in the members of each such category. Social frames determine the categories of persons that we may encounter (Goffman, 1975: 11).

Hence, the word "stigma" is used to designate an attribute meant to discredit the person, but it is worth underlining that it is better to use the term *relation* instead of *attribute*, because the attribute that stigmatizes a possessor can confirm the banality of another possessor: thus, it provides neither credit nor discredit.

It is understood that, by definition, we perceive a person with a stigma as not entirely human. Starting from this postulate, we practice all kinds of discriminations through which we reduce – sometimes unconsciously – the chances of that person. In order to explain his/her inferiority and to justify that he/she represents a danger, we construct a theory, an ideology of the stigmatized, which often serves to rationalizing an animosity. Every day, we use terms that designate specifically a stigma – such as retarded, daft – and we turn them into a source of images and metaphors; most of the times we no longer perceive their primary sense.

When we notice an imperfection, we are prone to assume a whole series; furthermore, sometimes we mistake the stigmatized person's defence reaction to his/her situation for the direct expression

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

of his/her deficiency. In this situation, we perceive both his/her deficiency and his/her reaction as a price paid for something done by him/her or by his/her parents, which justifies – in our eyes – the way we treat the person.

4. Family's reaction to the traumatic situation

Before the actual birth, the future parents go through a psychological preparation phase. They have dreams about the child and his/her future. Parents want a perfect child. We may or may not be aware of it, but we do fear a child with special needs. The newborn is always different from the child that the parents wanted, and they have to understand and to accept the change. However, if the newborn does not resemble at all the child of their dreams because he/she has a handicap, then the difference is too significant, and the parents have a hard time accepting the newborn. Once the disabled child is born, the parents suddenly lose forever the child of their dreams, the perfect, healthy child; in exchange, they get a child that generates trauma, fear, anxiousness and worry.

Not only did they lose the child they had dreamed of, for whom the parents had already built dreams, plans, hopes, but they also have to accept a reality that includes a disabled child. They now feel that all the preparations made for the child were useless, because this is not the child that the parents had dreamed of, but a dramatically different child. The dreams and thoughts prior to the child's birth are brutally cut off, and the parents have to deal with a very new situation: caring for and loving a foreign child. They discover the disability brutally and unexpectedly, which has important consequences for the exhausted mother.

Fischer and Riedesser define the *traumatic reaction* as a defence complex, where the psychophysical body continues to either destroy and eliminate or assimilate a foreign body, microorganisms that penetrated, respectively. A third possibility is to keep on living with the trauma as a foreign body inside, impossible to assimilate (Fischer, Riedesser, 2007: 102).

4. Models of reaction to traumatic events

4.1 Horowitz's model.

The model of experiencing the post-traumatic period coined by Horowitz and described by Fischer comprises five stages. The first is the

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

outcry, in the immediate aftermath of the trauma, with reactions ranging from manic gestures to overpowering fear (Fischer, 2007: 103). The second is the denial stage, comprising defence against the traumatic situation and even extreme avoidance mechanism; it sometimes includes the use of drugs, which prevent the person from experiencing pain. The third is the intrusive re-experiencing stage, when memories start to re-assess themselves. The fourth is the working through stage: coming to terms with the traumatic events and with their reaction; the person can even become stuck, a state accompanied by psychosomatic symptoms. Finally, the fifth stage is completion: the normal response – the capacity to remember the most important aspects of the traumatic event without having to think of it compulsively; the pathologic response – being stuck, accompanied by psychosomatic symptoms or extended avoidance behaviours, which turn into phobic character traits. The normal reaction is called "stress response."

4.2 The model of reaction to the traumatic situation of Kübler-Ross.

The American psychiatrist also proposes a five-stage model, which the person experiences after a serious prognostic. These reactions are called the "five stages of agony." When it refers to grief, they have a more specific name: "reaction to distress" (Kübler-Ross, 1969). The five stages are as follows: 1) *Denial* – upon learning the facts, the parents initially do not believe it; they are in shock, even in denial. During the first stage, parents usually keep on denying the disability. 2) *Anger* – usually manifested by the eagerness to get as many opinions from as many specialists, in the hope that one of them will reject the initial diagnostic. 3) *Bargaining* – in this stage, the parent accepts the diagnostic, but still hopes that the baby will be normal. During this stage, the parents refuse to believe some tests; they negotiate the diagnostic with the doctor. Hang-up can be accepted in this stage, but it is still the child who suffers, because the parents refuse to consider him/her different. They enrol him/her in normal schools, where he/she can have a hard time adapting (Serville & Mettey, 1996). 4) *Resignation and Depression* – it emerges gradually. The parents can no longer cope with the situation; they begin avoiding interpersonal contacts and even the relatives, mostly if stage two was full of reproaches. Overprotecting the child will prevent the emergence of the fifth stage. 5) *Acceptance* and reintegration of the

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

family – it involves major transformations of the family: some couples come out stronger and they even have another child, create support groups for parents, etc.

4.3 Stress and coping mechanisms.

Towards the end of the 70s, the concept of **coping** (adjustment) became a central variable in the psychological stress research, in order to understand the short- and long-term adaptive effects, the subjective well-being, the health. According to transactional theory, coping is defined as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1987: 141). The aforementioned definition underlines *four essential characteristics of coping*. The first is the role of cognitive processes and actions. The second is that coping is always a transaction between the person and the environment, thus involving continual quantitative and qualitative changes of this rapport and comprising mutual conditioning between coping, appraisal and emotion. The third is that it distinguishes between coping mechanisms and innate adaptation mechanisms; the first require effort. The fourth is that it underlines the existence of effective and less effective forms of coping.

Coping comprises three stages. The first is anticipation (warning), when the situation can be postponed or prevented, when the person can prepare for confrontation, when he/she can assess the "cost" of the confrontation. The second is confrontation, (impact) which includes the response, the redefinition of situation and the reassessment. The third is post-confrontation, when the personal meaning of what happened is assessed. Often the anticipation moment has more psychophysiological reactions than the actual confrontation. This determined the outline of the so-called anticipation stress. When there is no anticipatory moment, (e.g. in the intempestive impact with a certain stimulus) the psychophysiological reactions can occur post-confrontation (Lazarus, 1982).

The literature review on coping allows us to emphasize on several controversial points: Is coping a conscious or an unconscious response to stress factors? Is coping a personality trait or a process influenced by situation? How many dimensions does coping have? The most common classification is the one based on the dichotomy between

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

problem-focused and emotion-focused coping. Problem-focused adjustments are actions oriented directly towards solving, redefining or minimizing the stressful situation; they are also called instrumental adjustment. Emotion-focused adjustment – also called indirect adjustment – is person-oriented and it is meant to reduce or control the emotional response to stressors. This category also includes palliative strategies, such as the use of alcohol, painkillers and tranquilizers, relaxation techniques, etc.

There are controversies surrounding the effects of coping, too. Some authors identify coping with success, as well as with control of the situation and of emotional response. Several studies bring arguments to support that problem-focused coping strategies are associated positively with well-being, while the tendency of using emotion-focused coping strategies tend to be associated with a problematic mental health (Folkman et al., 1986).

There are studies that found the active adjustment forms to have a higher impact on the sympathetic nervous system, which influence, in their turn, the organization of cardiovascular system (Obrist, 1981). Many of the stressors in the environment cannot be controlled, but an effective coping strategy can allow a person to tolerate or ignore the stressor. We consider that the functionality or dysfunctionality of coping depends on who uses a certain strategy, on when, under which environmental and mental circumstances and on the type of threat.

Response to stress. Today there is no doubt that stress is a complex process that includes physiological and cognitive, emotional and behavioural reactions. It was only towards the end of the 60s that physiological response was approached interactively with the psychological one. There are researchers that still ignore the psychological aspects of response to stimuli. Biology-oriented researchers are persuaded that studies are more rigorous and objective if the focus is only on the physiological reactions. We consider that the emphasis on physiological stress alterations – a very useful approach, for that matter – does not exhaust the complexity of the phenomenon. Correlations between stimuli appraisals and physiological response, between the type of coping and the hormonal response pattern, between personality traits and reactive tendencies provide more pertinent study alternatives.

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

Consequences of stress. Certain authors include dysfunctions and psychosomatic conditions within the reactions to intense and lasting stressor; in this sense, stress emerges as a cumulative effect. We do not agree with this position and we underline the need to distinguish between the reactions and the consequences of stress. Consequences cannot be the effect of the confrontation with one stressor, but they are the result of the way in which the person manages to cope with several stressors in time. Consequences occur on several levels, as follows:

a. Cognitive: short-term and long-term memory impairment; decrease in the degree of concentration; increase in the level or errors and confusions; decrease in the capacity to make decisions, plans and to organize things; inhibitions and hang-ups; low tolerance to criticism; obsessive and irrational ideation; avoidance or denial.

b. Behavioural: professional instability and fluctuation, absenteeism; avoidance/ escape, passivity; aggressiveness/ intolerance/ disagreement; issues in the interpersonal relationships; increase use of alcohol, tobacco, coffee, painkillers; excess or loss of appetite, insomnias; suicide.

4.4 Analysis model for families in crisis – ABC-X Model

Hill analyzes families in crisis through a model called ABC-X (Hill 1949). This model allows Hill to distinguish between the life events that make the couple adapt and the crisis, characterized by the disarrangement resulted from the failure of the couple to adapt to stress.

There is now an equation that summarizes the conceptual outline of the research on family crisis: A (event) → interacting with B (the family's crisis-meeting resources) → interacting with C (the definitions the family makes of the event) → produces X (the crisis). The extent of the crisis actually represents the phenomenon of experiencing the stressor (A) with higher frequency and severity, thus defining the two dimensions (C) more frequently during a crisis. The crisis-proneness means experiencing the stressor event (A) more frequently and more severely, and the fact of defining these experiences (C) as crises more frequently than other families. In other words, the families prone to crises are more vulnerable to the aforementioned stressors and they are more likely to experience them because of their weak protective resources (B) and because they failed to learn from previous stressful events how to define those types of event as crisis-precipitator.

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

Consequently, the explanation for crisis-proneness concerns mainly the B and C factors of the equation.

Stressors (A)

Stress agents have a series of particularities, as follows : intrinsic to the couple relationship (the personality traits of the spouses, violence, etc) or extrinsic to it (floods that destroyed the assets of the family); sudden character; unexpected/ expected character; ambiguity level concerning the consequences produced; degree of stress severity; duration; extent to which the family members agree to expose themselves to stress; number of family members directly affected by stress.

When it comes to the birth of a disabled child, we notice that several of the aforementioned characteristics are intertwined: the sudden character, the degree of stress severity, duration, etc. All of these correlated characteristics have a negative impact upon the family, leading to alterations in the family status, in the relationships between the family members, changes in objectives, role changes, etc.

Factor B – the family's crisis-meeting resources

Robert Angell (1936) was the first family sociologist to have analyzed the B factor of our equation: a set of resources of the family group which, through their absence or presence, prevent the family from going into a crisis or they push it in the middle of a crisis. He proposes two concepts: family integration and family adaptability. He defines family integration as the coherent and unitary connections of the family, among which the most important ones are the common interests, the affection and the sense of economic interdependence. The concept of family adaptability refers to the family's capacity of overcoming the obstacles and of changing the normal course of things. Angell tried to reach to the latent predisposition of the family of acting in the face of troubles, in everyday life. In exchange, these latent action patterns – best observable during crises – are integrated by the family values. Angell found the possibility to explain the differences in the reactions of the families that resist to crises and that are more likely to overcome the crises through the two factors: integration and adaptability. The analysis of the cases suggests that family adaptability is of a crucial importance.

By using different concepts, several authors reached a common conclusion (Cavan & Ranck, 1938; Koos, 1946). In their opinion, the family resilient to stress has the following particularities: the existence of

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

an agreement on the role structure; subordination of personal interests to the family purposes; satisfaction within the family due to the satisfaction of physiological and emotional needs of its members; and the formulation of purposes through which the family advances as a group. Benefiting from them, the family is well-organized. Their lack indicates a disorganized family, which can explain the state of vulnerability before the crisis-precipitating event. In both studies, (Cavan & Ranck 1938; Koos, 1946) B factor represents the adequate/ inadequate character of family organization (related to the crisis-meeting resources).

Three categories of resources determine the capacity of stress resilience: personal resources of each individual; resources of the couple or of the family system; and resources related to the environment. The resources of the person are very important, but also his/her capacity of using them, his/her coping style. Studies have shown that the avoidant style produces more positive adaptation in the short-run and less positive adaptation in the long-run, compared to the strategies focused on resource use to solve problems (Suls & Fletcher, 1985).

The couple's resources include as follows: couple's capacity of collaboration; relationship cohesion; mutual support; communication skills. Studies have found higher marital satisfaction and a better mental state in couples that support each other (Carels & Baucom, 1999)

C factors – The definitions the family makes of the event

After studying the war-generated separation and reunion of the families, Hill and Boulding have found three possible definitions of the crisis-precipitating event: **(1)** and objective definition formulated by an impartial observer; **(2)** a cultural definition formulated by the community; and **(3)** a subjective definition provided by the family (Hill & Boulding, 1949). The third definition is the most relevant in determining the family's crisis-proneness. The researcher and the community are somewhere outside and they observe the situation but the family members are within the critical context, and the family's attitudes towards the event are all important in formulating the definition of the stressor.

In many cases, families with objective and adequate resources to cope with the obstacles break up because of the stress generated by disease or unemployment, precisely because they define such situations as difficult, as impossible to solve. Crisis-proneness is excessively high among individual with low self-esteem and high anxiety. The crisis-

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

proneness was also found to be related to what the family makes of the event, to whether it is seen or not as crisis-precipitator.

McCubbin and McCubbin talk about cognitive schemes of the family, schemes that comprise the attitudes of the family members concerning the degree of cohesion, the common objectives, the capacity of coping with stressors, the optimism regarding the future, the will to accept compromise solutions (McCubbin and McCubbin, 1989).

The crisis. General effects of the crisis upon family behaviour

In one of the most sensitive areas of family life, – the sexual area – sudden changes are notable. The frequency and pattern of sexual relationship change, and in some cases, it simply ceases. In relationship-related crises, if one member is seen as having produced the crisis, then his/her position is seriously shaken. The changes in the personality of the members reflect general anxiety, crisis-generated anxiety and, to a certain extent, each member with a responsibility experiences a pattern such as disorganization –> recovery –> reorganization. This is particularly apparent in case of grief, when the adjustments of the family members go through the following stages: mistrust → numbness → pain → adjustment by trial and error → resuming routine → recovery.

The family activities vary because of the crisis. Some families cease all activities until the "shame" goes away and they become a more closed system than ever. Some others become very "open" during the problematic period; they go out more than before in order to have contacts with others.

These are short-term effects of the crisis. The evidence of the long-term effects are contradictory. Cavan's findings show that, if the families are well-organized before a poverty-related crisis, they are likely to remain well-organized. Furthermore, it appears that prior critical experiences coped with represent predictors of recovery for the new crisis. Angell found that families remained well-integrated and adaptable, resilient to crises, because they overcame the critical period without changing the organization or role structure. By studying the German families after World War II that witnessed important bombings and that suffered the deprivations of denazification and post-war unemployment, Helmut Shelskz has found that the families came out of it more united, more resilient. He interpreted the phenomenon of the great family solidarity as a reaction to the big unstable society, where the house and

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

the family are true shelters and protectors from the uncertain post-war world.

By studying the families of refugees from the USSR in Europe and in the USA, Kent Geiger has found the families that had been persecuted politically to be more united rather than disorganized by the experience. Yet, the effect of economic deprivation upon these families was a decrease in the family solidarity. Hence, Geiger's study shows persecutions as having positive effects upon family unity, while the deterioration of living standards has having a negative impact. Once having been defeated a crisis, the family appears not to be able to marshal its forces sufficiently to face the next event; there is, in other words, a permanent defeat each time.

By summarizing the aforementioned evidence, we conclude the following: successes during crises consolidate the family, while the incapacity of facing critical periods has a destructive influence upon the structure and morale of the family.

4.5 The family adjustment and adaptation response model

This model is used to explain the way in which the families react to the changes in their lives. The model comprises two phases: pre-crisis adjustment and post-crisis adaptation.

The family adjustment phase. Prior to the crisis generated by family stress, (a) for instance, separation, there are often tensions such as lack of communication, pain or economic circumstances. The combination of these three factors produces shifts in the family needs. In order to adjust to the shifts, the family assesses its resources (b) and necessities before defining the stressor and deciding on a plan to face the new situation. Families experience either stress or worry when they conclude whether the situation is unpleasant or undesired. The family will respond in one of the three following ways: trying to avoid, deny or ignore the stressor as well as its demands, with the hope that it will just go away; eliminating the demands, by changing the stressor or by altering its definition; accepting the demands imposed by the stressor and making the necessary changes (assimilation).

The first two actions protect the family unity by minimizing the necessary changes. However, it is more likely for this to lead to poor adjustment. While assimilation can include a reallocation of resources, it is more likely to lead to a satisfactory result or to a lack of adjustment. In

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

many cases, the adjustment period is seen as a short-term response, adequate for administrating the change, the transformation and the demand. However, there are situations when the adjustment processes are not enough, which leads to a crisis.

The family adaptation phase. The emergence of a crisis is not a signal that the family failed to function correctly. The adaptation phase is characterized by the fact that the family admits the need for a change (by altering the rules, roles, purposes and/or action models). The processes appear on two distinct levels, as follows:

Level 1. Restructuring. In this phase, one or more members of the family become aware that they are unable to find the right combination or existing and new needs (load or factor aA). They share an understanding of the problem (cC) and they have a realistic image on the availability of resources. They may agree upon certain solutions that influence the passage of the family through this phase and they can implement them, for instance by using the resources to solve problems; a correct appraisal and an adequate definition of the situation can make families use the available solutions effectively. The family's efforts to solve the problem and the changes aim to administrate the demands, to make changes in order to adjust to demands and to re-establish order and stability within the family.

Level 2. Consolidation. The family passes to the consolidation level after initiating the change that leads to some restructuring. On this level, family focuses on trying to become a coherent unit. Now, one or more members of the family become aware that the family changed significantly. They try to facilitate a sharing of family conscience and an acceptance of the restructuring. Unlike the first level, the success of this level involves all members of the family. Changes are implemented (by learning from the mistakes) during the action phase. The family's attempts to coordinate and work together as a whole are called synergy. Identifying the interactions between all members of the family and the community in an attempt to redefine its role is called interfacing. While interfacing the needs and resources of the family to society's needs and resources is critical to a successful adaptation, it is seldom a complete success. Compromise involves a real estimate of the family circumstances and a desire to accept a less than perfect solution. The system can be maintained based on optimal moral levels and on the respect of the family members.

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

5. Conclusions

The disabled child invites certain specific responses, including the way in which the parents perceive the disability of their child, because this perception determines the way of relating to the child and the subsequent evolution/involution of his personality.

Parents can develop a form of self-protection manifested either by a sort of "anaesthesia" (passive form – the child is perceived as an object), or by an active type of relating (through which they try to prove that their child has the same responsibilities as the others, though he/she may not always succeed, that he/she is a "normal" child).

Precisely because it deals with both the disability of the child and the way in which he/she experiences it, and a recovery process that sometimes takes a lifetime, the family of the disabled child has to face challenges that govern the entire attitude of the family towards itself, as a distinct entity, with specific needs, and towards society, from which it often feels isolated because of the issues to solve.

In a family with a disabled child, routine changes, rituals are modified and the balance of intra-familial rapports shifts, as well as their equilibrium, which has significant effects on the functioning of the small social unit. This undisputable aspect has been pinpointed by most of the researchers within this field, who noticed that one could not separate the problems of the disabled child from the family's problems. Because it is a system, the family as a whole goes through periods of stress and exhaustion that can make it weak, or the family can learn how to adapt and it can come out stronger.

The attitude of the parents towards the disabled child depends on several factors, such as the degree of disability, the socio-cultural and emotional factors of the entourage, the family aspiration level, as well as the way in which the child meets the expectations of the parents from the perspective of social or intellectual success. The parents have the moral duty of learning how to treat their child, how to meet his/her demands in order to help him/her integrate in school and then in the profession. Parents can learn this behaviour – if they do not just have it instinctively – with the help of counsellors and/or therapists within this field.

All societies must take into account the special needs of some of its members and to meet these needs to the same extent and with the

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

same devotion as in case of the "*normal*" members of the social body on certain occasions or moments. The social protection policies and their concrete application methods also consider the members of the families of disabled persons, precisely as an acknowledgement of their fundamental role in the process of social protection, integration and inclusion.

References

Angell, R. C. (1936). *The family encounters the depression*. Gloucester: Peter Smith.

Carels, R. A., Baucom, D. H. (1999). Support in marriage: Factors associated with online perceptions of support helpfulness. *Journal of Family Psychology 13*(2), 131-144.

Cavan, R. S., Ranck, K. H. (1938). *The family and the depression: A study of one hundred Chicago families*. Chicago: The University of Chicago Press.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., Gruen, R. J. (1986). Dynamics of a stressful encounter: cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology 50*(5), 992-1003.

Iorga, M., Starcea, M., Munteanu, M., Sztankovszky, LZ.(2014) Psychological and Social Problems of Children with Chronic Kidney Disease. *European Journal of Science and Theology 10*(1), 179-188.

Serville, F., Mettey, R. (1996). *Mon enfant est différent*. Paris: Editions Frison Roche.

Goffman, E. (1975). *Stigmate. Les usages sociaux des handicaps*. Paris: Les Éditions de Minuit.

Fischer, G., Riedesser, P. (2007). *Tratat de psihotraumatologie*. Bucureşti: Trei.

Hill, R. (1949). Families under stress: Adjustment to the crises of war separation and reunion. New York: Harper & Brothers.

Koos, E. L. (1946). *Families in trouble*. Morningside Heights, NY: King's Crown.

Kübler-Ross, E. (1969). *On death and dying*. New York, NY: Macmillan Press.

Lazarus, R. S., Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality 1*(3), 141–169.

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.

Lazarus, R. S. (1982). Thoughts on the relations between emotion and cognition. *American Psychologist 37*, 1019–1024.

Lăzărescu, M. (1994). *Psihopatologie clinică*. Timişoara: Helicon.

McCubbin, M. A., McCubbin, H. I. (1989). Families coping with illness: the resilience model of family stress adjustment and adaptation. *Families health & illness*: *Perspectives on coping and intervention*. Danielson CB, Hamel-Bissel B, Winstead-Fry P, eds. St Louis: Mosby.

Obrist, P. A. (1981.) Cardiovascular psychophysiology: A perspective. New York: Plenum.

Paunescu, C. (1983). *Copilul deficient. Cunoasterea si educarea lui*. Editura Stiintifica si enciclopedica, Bucuresti.

Suls, J., Fletcher, B. (1985). The relative efficacy of avoidant and non-avoidant coping strategies: A meta-analysis. *Health Psychology 4*, 249-288.

Sztankovszky, L. Z., Iorga, M. (2015). Ethical aspects in treating adolescents with chronic disease. *Studia UBB Philosophia*; *61*(1), 81-88.

Biodata

Associate Professor PhD **Camelia SOPONARU**

Camelia SOPONARU is PhD associated professor at the Faculty of Psychology and Education Sciences, "Alexandru Ioan Cuza" University, Iasi, Romania. Scientific fields of competence: Social Psychology, Psychoanalysis, Evaluation of Personality through Projective Techniques and Cognitive-Behavioural Therapy. She is the author of *Espace individuel et groupal pour penser la transition en Roumanie. Approche psychosociologique clinique* and *Une institution en quatre lectures à travers une activité de groupe: l'Hygiène Mentale*. She published more than 20 studies and she is co-author of more than 30 chapterbooks.

PhD Lecturer **Magdalena IORGA**

Magdalena IORGA is PhD lecturer University of Medicine and Pharmacy "Gr. T. Popa" of Iasi and clinical psychologist at Santa Maria" Child Hospital of Iasi. Interested in the aria of psychology, psychotherapy, personality problems and health. She published 3 books and more than 40 articles published in international journals and proceedings.

Soponaru, C., Iorga, M. (2015). Families with a Disabled Child, between Stress and Acceptance. A Theoretical Approach. Revista Romaneasca pentru Educatie Multidimensionala, 7(1), 57-73.